

105TH CONGRESS  
1ST SESSION

# S. 356

To amend the Internal Revenue Code of 1986, the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and titles XVIII and XIX of the Social Security Act to assure access to emergency medical services under group health plans, health insurance coverage, and the medicare and medicaid programs.

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## IN THE SENATE OF THE UNITED STATES

FEBRUARY 25, 1997

Mr. GRAHAM (for himself, Mr. HUTCHINSON, Ms. MIKULSKI, and Mr. CHAFEE) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To amend the Internal Revenue Code of 1986, the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and titles XVIII and XIX of the Social Security Act to assure access to emergency medical services under group health plans, health insurance coverage, and the medicare and medicaid programs.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

### 3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Access to Emergency Medical Services Act of 1997”.

1 (b) TABLE OF CONTENTS.—The table of contents of  
 2 this Act is as follows:

- Sec. 1. Short title; table of contents.
- Sec. 2. Amendments to the Internal Revenue Code of 1986.
- Sec. 3. Amendments to the Employee Retirement Income Security Act of 1974.
- Sec. 4. Amendments to the Public Health Service Act relating to the group market.
- Sec. 5. Amendments to the Public Health Service Act relating to the individual market.
- Sec. 6. Application to private coverage for medicare and medicaid beneficiaries.
- Sec. 7. Establishment of guidelines.

3 **SEC. 2. AMENDMENTS TO THE INTERNAL REVENUE CODE**  
 4 **OF 1986.**

5 (a) IN GENERAL.—Subtitle K of the Internal Reve-  
 6 nue Code of 1986 (as added by section 401(a) of the  
 7 Health Insurance Portability and Accountability Act of  
 8 1996) is amended—

9 (1) by striking all that precedes section 9801  
 10 and inserting the following:

11 **“Subtitle K—Group Health Plan**  
 12 **Requirements**

“CHAPTER 100. Group health plan requirements.

13 **“CHAPTER 100—GROUP HEALTH PLAN**  
 14 **REQUIREMENTS**

“Subchapter A. Requirements relating to portability, access, and renewability.

“Subchapter B. Other requirements.

“Subchapter C. General provisions.

15 **“Subchapter A—Requirements Relating to**  
 16 **Portability, Access, and Renewability**

“Sec. 9801. Increased portability through limitation on preexist-  
 ing condition exclusions.

“Sec. 9802. Prohibiting discrimination against individual participants and beneficiaries based on health status.

“Sec. 9803. Guaranteed renewability in multiemployer plans and certain multiple employer welfare arrangements.”,

1 (2) by redesignating sections 9804, 9805, and  
 2 9806 as sections 9831, 9832, and 9833, respectively,  
 3 (3) by inserting before section 9831 (as so re-  
 4 designated) the following:

5 **“Subchapter C—General Provisions**

“Sec. 9831. General exceptions.

“Sec. 9832. Definitions.

“Sec. 9833. Regulations.”, and

6 (4) by inserting after section 9803 the follow-  
 7 ing:

8 **“Subchapter B—Other Requirements**

“Sec. 9811. Assuring equitable coverage of emergency services, maintenance care, and post-stabilization care.

9 **“SEC. 9811. ASSURING EQUITABLE COVERAGE OF EMER-**  
 10 **GENCY SERVICES, MAINTENANCE CARE, AND**  
 11 **POST-STABILIZATION CARE.**

12 **“(a) PROHIBITION OF CERTAIN RESTRICTIONS ON**  
 13 **COVERAGE OF EMERGENCY SERVICES.—**

14 **“(1) IN GENERAL.—**If a group health plan pro-  
 15 vides any benefits with respect to emergency services  
 16 (as defined in paragraph (2)(B)), the plan (and any  
 17 health insurance issuer offering health insurance  
 18 coverage in connection with such a plan) shall cover

1 emergency services furnished to a participant or ben-  
 2 eficiary of the plan—

3 “(A) without the need for any prior au-  
 4 thorization determination,

5 “(B) subject to paragraph (3), whether or  
 6 not the physician or provider furnishing such  
 7 services is a participating physician or provider  
 8 with respect to such services, and

9 “(C) subject to paragraph (3), without re-  
 10 gard to any other term or condition of such  
 11 plan or coverage (other than an exclusion of  
 12 benefits, or an affiliation or waiting period, per-  
 13 mitted under section 9801).

14 “(2) EMERGENCY SERVICES; EMERGENCY MEDI-  
 15 CAL CONDITION.—For purposes of this section—

16 “(A) EMERGENCY MEDICAL CONDITION  
 17 BASED ON PRUDENT LAYPERSON.—The term  
 18 ‘emergency medical condition’ means a medical  
 19 condition manifesting itself by acute symptoms  
 20 of sufficient severity (including severe pain)  
 21 such that a prudent layperson, who possesses  
 22 an average knowledge of health and medicine,  
 23 could reasonably expect the absence of imme-  
 24 diate medical attention to result in—

1 “(i) placing the health of the individ-  
2 ual (or, with respect to a pregnant woman,  
3 the health of the woman or her unborn  
4 child) in serious jeopardy,

5 “(ii) serious impairment to bodily  
6 functions, or

7 “(iii) serious dysfunction of any bodily  
8 organ or part.

9 “(B) EMERGENCY SERVICES.—The term  
10 ‘emergency services’ means—

11 “(i) a medical screening examination  
12 (as required under section 1867 of the So-  
13 cial Security Act) that is within the capa-  
14 bility of the emergency department of a  
15 hospital, including ancillary services rou-  
16 tinely available to the emergency depart-  
17 ment, to evaluate an emergency medical  
18 condition (as defined in subparagraph  
19 (A)), and

20 “(ii) within the capabilities of the  
21 staff and facilities available at the hospital,  
22 such further medical examination and  
23 treatment as are required under section  
24 1867 of the Social Security Act to stabilize  
25 the patient.

“(C) TRAUMA AND BURN CENTERS.—The provisions of clause (ii) of subparagraph (B) apply to a trauma or burn center, in a hospital, that—

“(i) is designated by the State, a regional authority of the State, or by the designee of the State, or

“(ii) is in a State that has not made such designations and meets medically recognized national standards.

“(3) APPLICATION OF NETWORK RESTRICTION PERMITTED IN CERTAIN CASES.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), if a group health plan (and an issuer of health insurance coverage in connection with such a plan) denies, limits, or otherwise differentiates in coverage or payment for benefits other than emergency services on the basis that the physician or provider of such services is a nonparticipating physician or provider, the plan and issuer may deny, limit, or differentiate in coverage or payment for emergency services on such basis.

“(B) NETWORK RESTRICTIONS NOT PERMITTED IN CERTAIN EXCEPTIONAL CASES.—

1           The denial or limitation of, or differentiation in,  
 2           coverage or payment of benefits for emergency  
 3           services under subparagraph (A) shall not apply  
 4           in the following cases:

5                   “(i) CIRCUMSTANCES BEYOND CON-  
 6                   TROL OF PARTICIPANT OR BENEFICIARY.—

7                   The participant or beneficiary is unable to  
 8                   go to a participating hospital for such serv-  
 9                   ices due to circumstances beyond the con-  
 10                  trol of the participant or beneficiary (as  
 11                  determined consistent with guidelines and  
 12                  subparagraph (C)).

13                  “(ii) LIKELIHOOD OF AN ADVERSE  
 14                  HEALTH CONSEQUENCE BASED ON  
 15                  LAYPERSON’S JUDGMENT.—A prudent  
 16                  layperson possessing an average knowledge  
 17                  of health and medicine could reasonably  
 18                  believe that, under the circumstances and  
 19                  consistent with guidelines, the time re-  
 20                  quired to go to a participating hospital for  
 21                  such services could result in any of the ad-  
 22                  verse health consequences described in a  
 23                  clause of subsection (a)(2)(A).

1                   “(iii) PHYSICIAN REFERRAL.—A par-  
 2                   ticipating physician or other person au-  
 3                   thorized by the plan refers the participant  
 4                   or beneficiary to an emergency department  
 5                   of a hospital and does not specify an emer-  
 6                   gency department of a hospital that is a  
 7                   participating hospital with respect to such  
 8                   services.

9                   “(C) APPLICATION OF ‘BEYOND CONTROL’  
 10                  STANDARDS.—For purposes of applying sub-  
 11                  paragraph (B)(i), receipt of emergency services  
 12                  from a nonparticipating hospital shall be treat-  
 13                  ed under the guidelines as being ‘due to cir-  
 14                  cumstances beyond the control of the partici-  
 15                  pant or beneficiary’ if any of the following con-  
 16                  ditions are met:

17                   “(i) UNCONSCIOUS.—The participant  
 18                   or beneficiary was unconscious or in an  
 19                   otherwise altered mental state at the time  
 20                   of initiation of the services.

21                   “(ii) AMBULANCE DELIVERY.—The  
 22                   participant or beneficiary was transported  
 23                   by an ambulance or other emergency vehi-  
 24                   cle directed by a person other than the



1 participant or beneficiary to the non-  
2 participating hospital in which the services  
3 were provided.

4 “(iii) NATURAL DISASTER.—A natural  
5 disaster or civil disturbance prevented the  
6 participant or beneficiary from presenting  
7 to a participating hospital for the provision  
8 of such services.

9 “(iv) NO GOOD FAITH EFFORT TO IN-  
10 FORM OF CHANGE IN PARTICIPATION DUR-  
11 ING A CONTRACT YEAR.—The status of the  
12 hospital changed from a participating hos-  
13 pital to a nonparticipating hospital with re-  
14 spect to emergency services during a con-  
15 tract year and the plan or issuer failed to  
16 make a good faith effort to notify the par-  
17 ticipant or beneficiary involved of such  
18 change.

19 “(v) OTHER CONDITIONS.—There  
20 were other factors (such as those identified  
21 in guidelines) that prevented the partici-  
22 pant or beneficiary from controlling selec-  
23 tion of the hospital in which the services  
24 were provided.

1       “(b) ASSURING COORDINATED COVERAGE OF MAIN-  
2   TENANCE CARE AND POST-STABILIZATION CARE.—

3               “(1) IN GENERAL.—In the case of a participant  
4       or beneficiary who is covered under a group health  
5       plan (or under health insurance coverage issued by  
6       a health insurance issuer offered in connection with  
7       such a plan) and who has received emergency serv-  
8       ices pursuant to a screening evaluation conducted  
9       (or supervised) by a treating physician at a hospital  
10      that is a nonparticipating provider with respect to  
11      emergency services, if—

12              “(A) pursuant to such evaluation, the phy-  
13      sician identifies post-stabilization care (as de-  
14      fined in paragraph (3)(B)) that is required by  
15      the participant or beneficiary,

16              “(B) the plan or coverage provides benefits  
17      with respect to the care so identified and the  
18      plan requires (but for this subsection) an af-  
19      firmative prior authorization determination as a  
20      condition of coverage of such care, and

21              “(C) the treating physician (or another in-  
22      dividual acting on behalf of such physician) ini-  
23      tiates, not later than 30 minutes after the time

1 the treating physician determines that the con-  
2 dition of the participant or beneficiary is sta-  
3 bilized, a good faith effort to contact a physi-  
4 cian or other person authorized by the plan or  
5 issuer (by telephone or other means) to obtain  
6 an affirmative prior authorization determination  
7 with respect to the care,

8 then, without regard to terms and conditions speci-  
9 fied in paragraph (2) the plan or issuer shall cover  
10 maintenance care (as defined in paragraph (3)(A))  
11 furnished to the participant or beneficiary during  
12 the period specified in paragraph (4) and shall cover  
13 post-stabilization care furnished to the participant or  
14 beneficiary during the period beginning under para-  
15 graph (5) and ending under paragraph (6).

16 “(2) TERMS AND CONDITIONS WAIVED.—The  
17 terms and conditions (of a plan or coverage) de-  
18 scribed in this paragraph that are waived under  
19 paragraph (1) are as follows:

20 “(A) The need for any prior authorization  
21 determination.

22 “(B) Any limitation on coverage based on  
23 whether or not the physician or provider fur-  
24 nishing the care is a participating physician or  
25 provider with respect to such care.

1           “(C) Any other term or condition of the  
 2           plan or coverage (other than an exclusion of  
 3           benefits, or an affiliation or waiting period, per-  
 4           mitted under section 9801 and other than a re-  
 5           quirement relating to medical necessity for cov-  
 6           erage of benefits).

7           “(3) MAINTENANCE CARE AND POST-STA-  
 8           BILIZATION CARE DEFINED.—In this subsection:

9           “(A) MAINTENANCE CARE.—The term  
 10          ‘maintenance care’ means, with respect to an  
 11          individual who is stabilized after provision of  
 12          emergency services, medically necessary items  
 13          and services (other than emergency services)  
 14          that are required by the individual to ensure  
 15          that the individual remains stabilized during  
 16          the period described in paragraph (4).

17          “(B) POST-STABILIZATION CARE.—The  
 18          term ‘post-stabilization care’ means, with re-  
 19          spect to an individual who is determined to be  
 20          stable pursuant to a medical screening examina-  
 21          tion or who is stabilized after provision of emer-  
 22          gency services, medically necessary items and  
 23          services (other than emergency services and  
 24          other than maintenance care) that are required  
 25          by the individual.

1           “(4) PERIOD OF REQUIRED COVERAGE OF  
 2 MAINTENANCE CARE.—The period of required cov-  
 3 erage of maintenance care of an individual under  
 4 this subsection begins at the time of the request (or  
 5 the initiation of the good faith effort to make the re-  
 6 quest) under paragraph (1)(C) and ends when—

7                   “(A) the individual is discharged from the  
 8 hospital;

9                   “(B) a physician (designated by the plan  
 10 or issuer involved) and with privileges at the  
 11 hospital involved arrives at the emergency de-  
 12 partment of the hospital and assumes respon-  
 13 sibility with respect to the treatment of the in-  
 14 dividual; or

15                   “(C) the treating physician and the plan or  
 16 issuer agree to another arrangement with re-  
 17 spect to the care of the individual.

18           “(5) WHEN POST-STABILIZATION CARE RE-  
 19 QUIRED TO BE COVERED.—

20                   “(A) WHEN TREATING PHYSICIAN UNABLE  
 21 TO COMMUNICATE REQUEST.—If the treating  
 22 physician or other individual makes the good  
 23 faith effort to request authorization under para-  
 24 graph (1)(C) but is unable to communicate the

1 request directly with an authorized person re-  
2 ferred to in such paragraph within 30 minutes  
3 after the time of initiating such effort, then  
4 post-stabilization care is required to be covered  
5 under this subsection beginning at the end of  
6 such 30-minute period.

7 “(B) WHEN ABLE TO COMMUNICATE RE-  
8 QUEST, AND NO TIMELY RESPONSE.—

9 “(i) IN GENERAL.—If the treating  
10 physician or other individual under para-  
11 graph (1)(C) is able to communicate the  
12 request within the 30-minute period de-  
13 scribed in subparagraph (A), the post-sta-  
14 bilization care requested is required to be  
15 covered under this subsection beginning 30  
16 minutes after the time when the plan or is-  
17 suer receives the request unless a person  
18 authorized by the plan or issuer involved  
19 communicates (or makes a good faith ef-  
20 fort to communicate) a denial of the re-  
21 quest for the prior authorization deter-  
22 mination within 30 minutes of the time  
23 when the plan or issuer receives the re-  
24 quest and the treating physician does not  
25 request under clause (ii) to communicate

1 directly with an authorized physician con-  
2 cerning the denial.

3 “(ii) REQUEST FOR DIRECT PHYSI-  
4 CIAN-TO-PHYSICIAN COMMUNICATION CON-  
5 CERNING DENIAL.—If a denial of a request  
6 is communicated under clause (i), the  
7 treating physician may request to commu-  
8 nicate respecting the denial directly with a  
9 physician who is authorized by the plan or  
10 issuer to deny or affirm such a denial.

11 “(C) WHEN NO TIMELY RESPONSE TO RE-  
12 QUEST FOR PHYSICIAN-TO-PHYSICIAN COMMU-  
13 NICATION.—If a request for physician-to-physi-  
14 cian communication is made under subpara-  
15 graph (B)(ii), the post-stabilization care re-  
16 quested is required to be covered under this  
17 subsection beginning 30 minutes after the time  
18 when the plan or issuer receives the request  
19 from a treating physician unless a physician,  
20 who is authorized by the plan or issuer to re-  
21 verse or affirm the initial denial of the care,  
22 communicates (or makes a good faith effort to  
23 communicate) directly with the treating physi-  
24 cian within such 30-minute period.

1           “(D) DISAGREEMENTS OVER POST-STA-  
2           BILIZATION CARE.—If, after a direct physician-  
3           to-physician communication under subpara-  
4           graph (C), the denial of the request for the  
5           post-stabilization care is not reversed and the  
6           treating physician communicates to the plan or  
7           issuer involved a disagreement with such deci-  
8           sion, the post-stabilization care requested is re-  
9           quired to be covered under this subsection be-  
10          ginning as follows:

11               “(i) DELAY TO ALLOW FOR PROMPT  
12               ARRIVAL OF PHYSICIAN ASSUMING RE-  
13               SPONSIBILITY.—If the plan or issuer com-  
14               municates that a physician (designated by  
15               the plan or issuer) with privileges at the  
16               hospital involved will arrive promptly (as  
17               determined under guidelines) at the emer-  
18               gency department of the hospital in order  
19               to assume responsibility with respect to the  
20               treatment of the participant or beneficiary  
21               involved, the required coverage of the post-  
22               stabilization care begins after the passage  
23               of such time period as would allow the  
24               prompt arrival of such a physician.



1                   “(ii) OTHER CASES.—If the plan or  
 2                   issuer does not so communicate, the re-  
 3                   quired coverage of the post-stabilization  
 4                   care begins immediately.

5                   “(6) NO REQUIREMENT OF COVERAGE OF POST-  
 6                   STABILIZATION CARE IF ALTERNATE PLAN OF  
 7                   TREATMENT.—

8                   “(A) IN GENERAL.—Coverage of post-sta-  
 9                   bilization care is not required under this sub-  
 10                  section with respect to an individual when—

11                  “(i) subject to subparagraph (B), a  
 12                  physician (designated by the plan or issuer  
 13                  involved) and with privileges at the hos-  
 14                  pital involved arrives at the emergency de-  
 15                  partment of the hospital and assumes re-  
 16                  sponsibility with respect to the treatment  
 17                  of the individual; or

18                  “(ii) the treating physician and the  
 19                  plan or issuer agree to another arrange-  
 20                  ment with respect to the post-stabilization  
 21                  care (such as an appropriate transfer of  
 22                  the individual involved to another facility  
 23                  or an appointment for timely followup  
 24                  treatment for the individual).

1           “(B) SPECIAL RULE WHERE ONCE CARE  
 2           INITIATED.—Required coverage of requested  
 3           post-stabilization care shall not end by reason  
 4           of subparagraph (A)(i) during an episode of  
 5           care (as determined by guidelines) if the treat-  
 6           ing physician initiated such care (consistent  
 7           with a previous paragraph) before the arrival of  
 8           a physician described in such subparagraph.

9           “(7) CONSTRUCTION.—Nothing in this sub-  
 10          section shall be construed as—

11           “(A) preventing a plan or issuer from au-  
 12           thorizing coverage of maintenance care or post-  
 13           stabilization care in advance or at any time; or

14           “(B) preventing a treating physician or  
 15           other individual described in paragraph (1)(C)  
 16           and a plan or issuer from agreeing to modify  
 17           any of the time periods specified in paragraphs  
 18           (5) as it relates to cases involving such persons.

19          “(c) LIMITS ON COST-SHARING FOR SERVICES FUR-  
 20          NISHED IN EMERGENCY DEPARTMENTS.—If a group  
 21          health plan provides any benefits with respect to emer-  
 22          gency services, the plan (or a health insurance issuer offer-  
 23          ing health insurance coverage in connection with such a  
 24          plan) may impose cost sharing with respect to such serv-  
 25          ices only if the following conditions are met:

1           “(1) LIMITATIONS ON COST-SHARING DIF-  
2       FERENTIAL FOR NONPARTICIPATING PROVIDERS.—

3           “(A) NO DIFFERENTIAL FOR CERTAIN  
4       SERVICES.—In the case of services furnished  
5       under the circumstances described in clause (i),  
6       (ii), or (iii) of subsection (a)(3)(B) (relating to  
7       circumstances beyond the control of the bene-  
8       ficiary, the likelihood of an adverse health con-  
9       sequence based on layperson’s judgment, and  
10      physician referral), the cost-sharing for such  
11      services provided by a nonparticipating provider  
12      or physician does not exceed the cost-sharing  
13      for such services provided by a participating  
14      provider or physician.

15          “(B) ONLY REASONABLE DIFFERENTIAL  
16      FOR OTHER SERVICES.—In the case of other  
17      emergency services, any differential by which  
18      the cost-sharing for such services provided by a  
19      nonparticipating provider or physician exceeds  
20      the cost-sharing for such services provided by a  
21      participating provider or physician is reasonable  
22      (as determined under guidelines).

23          “(2) ONLY REASONABLE DIFFERENTIAL BE-  
24      TWEEN EMERGENCY SERVICES AND OTHER SERV-  
25      ICES.—Any differential by which the cost-sharing for

1 services furnished in an emergency department ex-  
 2 ceeds the cost-sharing for such services furnished in  
 3 another setting is reasonable (as determined under  
 4 guidelines).

5 “(3) CONSTRUCTION.—Nothing in paragraph  
 6 (1)(B) or (2) shall be construed as authorizing  
 7 guidelines other than guidelines that establish maxi-  
 8 mum cost-sharing differentials.

9 “(d) INFORMATION ON ACCESS TO EMERGENCY  
 10 SERVICES.—A group health plan (or a health insurance  
 11 issuer, to the extent a health insurance issuer offers group  
 12 health insurance coverage in connection with such a plan)  
 13 shall provide education to participants and beneficiaries  
 14 of the plan on—

15 “(1) coverage of emergency services (as defined  
 16 in subsection (a)(2)(B)) by the plan in accordance  
 17 with the provisions of this section,

18 “(2) the appropriate use of emergency services,  
 19 including use of the 911 telephone system or its  
 20 local equivalent,

21 “(3) any cost sharing applicable to emergency  
 22 services,

23 “(4) the process and procedures of the plan for  
 24 obtaining emergency services, and

25 “(5) the locations of—

1 “(A) emergency departments, and

2 “(B) other settings,

3 in which participating physicians and hospitals pro-  
4 vide emergency services and post-stabilization care.

5 “(e) GENERAL DEFINITIONS.—For purposes of this  
6 section:

7 “(1) COST SHARING.—The term ‘cost sharing’  
8 means any deductible, coinsurance amount, copay-  
9 ment or other out-of-pocket payment (other than  
10 premiums or enrollment fees) that a group health  
11 plan (or a health insurance issuer offering group  
12 health insurance issuer in connection with such a  
13 plan) imposes on participants and beneficiaries of  
14 the plan with respect to the coverage of benefits.

15 “(2) GOOD FAITH EFFORT.—The term ‘good  
16 faith effort’ has the meaning given such term in  
17 guidelines and requires such appropriate documenta-  
18 tion as is specified under such guidelines.

19 “(3) GUIDELINES.—The term ‘guidelines’  
20 means guidelines established in accordance with sec-  
21 tion 7 of the Access to Emergency Medical Services  
22 Act of 1997.

23 “(4) NONPARTICIPATING PHYSICIAN OR PRO-  
24 VIDER.—The term ‘nonparticipating physician or  
25 provider’ means, with respect to health care items

1 and services furnished to a participant or beneficiary  
2 of a group health plan, a physician or provider that  
3 is not a participating physician or provider for such  
4 services.

5 “(5) PARTICIPATING PHYSICIAN OR PRO-  
6 VIDER.—The term ‘participating physician or pro-  
7 vider’ means, with respect to health care items and  
8 services furnished to a participant or beneficiary of  
9 a group health plan, a physician or provider that  
10 furnishes such items and services under a contract  
11 or other arrangement with such plan (or with a  
12 health insurance issuer offering group health insur-  
13 ance coverage in connection with such a plan).

14 “(6) PRIOR AUTHORIZATION DETERMINA-  
15 TION.—The term ‘prior authorization determination’  
16 means, with respect to items and services for which  
17 coverage may be provided under a group health plan,  
18 a determination (before the provision of the items  
19 and services and as a condition of coverage of the  
20 items and services under the plan) of whether or not  
21 such items and services will be covered under the  
22 plan.

23 “(7) STABILIZE.—The term ‘to stabilize’  
24 means, with respect to an emergency medical condi-  
25 tion, to provide (in complying with section 1867 of

1 the Social Security Act) such medical treatment of  
 2 the condition as may be necessary to assure, within  
 3 reasonable medical probability, that no material de-  
 4 terioration of the condition is likely to result from or  
 5 occur during the transfer of the individual from the  
 6 facility.

7 “(8) STABILIZED.—The term ‘stabilized’  
 8 means, with respect to an emergency medical condi-  
 9 tion, that no material deterioration of the condition  
 10 is likely, within reasonable medical probability, to re-  
 11 sult from or occur before an individual can be trans-  
 12 ferred from the facility, in compliance with the re-  
 13 quirements of section 1867 of the Social Security  
 14 Act.

15 “(9) TREATING PHYSICIAN.—The term ‘treat-  
 16 ing physician’ includes a treating health care profes-  
 17 sional who is licensed under State law to provide  
 18 emergency services other than under the supervision  
 19 of a physician.”

20 (b) CONFORMING AMENDMENTS.—

21 (1) Chapter 100 of such Code (as added by sec-  
 22 tion 401 of the Health Insurance Portability and Ac-  
 23 countability Act of 1996 and as previously amended  
 24 by this section) is further amended—

1 (A) in the last sentence of section  
 2 9801(c)(1), by striking “section 9805(c)” and  
 3 inserting “section 9832(c)”;

4 (B) in section 9831(b), by striking  
 5 “9805(c)(1)” and inserting “9832(c)(1)”;

6 (C) in section 9831(c)(1), by striking  
 7 “9805(c)(2)” and inserting “9832(c)(2)”;

8 (D) in section 9831(c)(2), by striking  
 9 “9805(c)(3)” and inserting “9832(c)(3)”;

10 (E) in section 9831(c)(3), by striking  
 11 “9805(c)(4)” and inserting “9832(c)(4)”.

12 (2) Section 4980D of such Code (as added by  
 13 section 402 of the Health Insurance Portability and  
 14 Accountability Act of 1996) is amended—

15 (A) in subsection (c)(3)(B)(i)(I), by strik-  
 16 ing “9805(d)(3)” and inserting “9832(d)(3)”;

17 (B) in subsection (d)(1), by inserting  
 18 “(other than a failure attributable to section  
 19 9811)” after “on any failure”;

20 (C) in subsection (d)(3), by striking  
 21 “9805” and inserting “9832”;

22 (D) in subsection (f)(1), by striking  
 23 “9805(a)” and inserting “9832(a)”.

24 (3) The table of subtitles for such Code is  
 25 amended by striking the item relating to subtitle K



1 (as added by section 401(b) of the Health Insurance  
2 Portability and Accountability Act of 1996) and in-  
3 serting the following new item:

“SUBTITLE K. Group health plan requirements.”

4 (c) EFFECTIVE DATE.—(1) Subject to paragraph (2),  
5 the amendments made by this section shall apply to group  
6 health plans for plan years beginning on or after 18  
7 months after the date of the enactment of this Act.

8 (2) In the case of a group health plan maintained  
9 pursuant to 1 or more collective bargaining agreements  
10 between employee representatives and 1 or more employ-  
11 ers ratified before the date of enactment of this Act, the  
12 amendments made by this section shall not apply to plan  
13 years beginning before the later of—

14 (A) the date on which the last collective bar-  
15 gaining agreements relating to the plan terminates  
16 (determined without regard to any extension thereof  
17 agreed to after the date of enactment of this Act),  
18 or

19 (B) 18 months after the date of the enactment  
20 of this Act.

21 For purposes of subparagraph (A), any plan amendment  
22 made pursuant to a collective bargaining agreement relat-  
23 ing to the plan which amends the plan solely to conform  
24 to any requirement added by this section shall not be

1 treated as a termination of such collective bargaining  
2 agreement.

3 **SEC. 3. AMENDMENTS TO THE EMPLOYEE RETIREMENT IN-**  
4 **COME SECURITY ACT OF 1974.**

5 (a) IN GENERAL.—Subpart B of part 7 of subtitle  
6 B of title I of the Employee Retirement Income Security  
7 Act of 1974 is amended by adding at the end the following  
8 new section:

9 **“SEC. 713. ASSURING EQUITABLE COVERAGE OF EMER-**  
10 **GENCY SERVICES, MAINTENANCE CARE, AND**  
11 **POST-STABILIZATION CARE.**

12 “(a) PROHIBITION OF CERTAIN RESTRICTIONS ON  
13 COVERAGE OF EMERGENCY SERVICES.—

14 “(1) IN GENERAL.—If a group health plan pro-  
15 vides any benefits with respect to emergency services  
16 (as defined in paragraph (2)(B)), the plan (and any  
17 health insurance issuer offering health insurance  
18 coverage in connection with such a plan) shall cover  
19 emergency services furnished to a participant or ben-  
20 eficiary of the plan—

21 “(A) without the need for any prior au-  
22 thorization determination,

23 “(B) subject to paragraph (3), whether or  
24 not the physician or provider furnishing such

1 services is a participating physician or provider  
 2 with respect to such services, and

3 “(C) subject to paragraph (3), without re-  
 4 gard to any other term or condition of such  
 5 plan or coverage (other than an exclusion of  
 6 benefits, or an affiliation or waiting period, per-  
 7 mitted under section 701).

8 “(2) EMERGENCY SERVICES; EMERGENCY MEDI-  
 9 CAL CONDITION.—For purposes of this section—

10 “(A) EMERGENCY MEDICAL CONDITION  
 11 BASED ON PRUDENT LAYPERSON.—The term  
 12 ‘emergency medical condition’ means a medical  
 13 condition manifesting itself by acute symptoms  
 14 of sufficient severity (including severe pain)  
 15 such that a prudent layperson, who possesses  
 16 an average knowledge of health and medicine,  
 17 could reasonably expect the absence of imme-  
 18 diate medical attention to result in—

19 “(i) placing the health of the individ-  
 20 ual (or, with respect to a pregnant woman,  
 21 the health of the woman or her unborn  
 22 child) in serious jeopardy,

23 “(ii) serious impairment to bodily  
 24 functions, or

1 “(iii) serious dysfunction of any bodily  
2 organ or part.

3 “(B) EMERGENCY SERVICES.—The term  
4 ‘emergency services’ means—

5 “(i) a medical screening examination  
6 (as required under section 1867 of the So-  
7 cial Security Act) that is within the capa-  
8 bility of the emergency department of a  
9 hospital, including ancillary services rou-  
10 tinely available to the emergency depart-  
11 ment, to evaluate an emergency medical  
12 condition (as defined in subparagraph  
13 (A)), and

14 “(ii) within the capabilities of the  
15 staff and facilities available at the hospital,  
16 such further medical examination and  
17 treatment as are required under section  
18 1867 of the Social Security Act to stabilize  
19 the patient.

20 “(C) TRAUMA AND BURN CENTERS.—The  
21 provisions of clause (ii) of subparagraph (B)  
22 apply to a trauma or burn center, in a hospital,  
23 that—

1 “(i) is designated by the State, a re-  
 2 gional authority of the State, or by the  
 3 designee of the State, or

4 “(ii) is in a State that has not made  
 5 such designations and meets medically rec-  
 6 ognized national standards.

7 “(3) APPLICATION OF NETWORK RESTRICTION  
 8 PERMITTED IN CERTAIN CASES.—

9 “(A) IN GENERAL.—Except as provided in  
 10 subparagraph (B), if a group health plan (and  
 11 an issuer of health insurance coverage in con-  
 12 nection with such a plan) denies, limits, or oth-  
 13 erwise differentiates in coverage or payment for  
 14 benefits other than emergency services on the  
 15 basis that the physician or provider of such  
 16 services is a nonparticipating physician or pro-  
 17 vider, the plan and issuer may deny, limit, or  
 18 differentiate in coverage or payment for emer-  
 19 gency services on such basis.

20 “(B) NETWORK RESTRICTIONS NOT PER-  
 21 MITTED IN CERTAIN EXCEPTIONAL CASES.—  
 22 The denial or limitation of, or differentiation in,  
 23 coverage or payment of benefits for emergency  
 24 services under subparagraph (A) shall not apply  
 25 in the following cases:

1 “(i) CIRCUMSTANCES BEYOND CON-  
2 TROL OF PARTICIPANT OR BENEFICIARY.—  
3 The participant or beneficiary is unable to  
4 go to a participating hospital for such serv-  
5 ices due to circumstances beyond the con-  
6 trol of the participant or beneficiary (as  
7 determined consistent with guidelines and  
8 subparagraph (C)).

9 “(ii) LIKELIHOOD OF AN ADVERSE  
10 HEALTH CONSEQUENCE BASED ON  
11 LAYPERSON’S JUDGMENT.—A prudent  
12 layperson possessing an average knowledge  
13 of health and medicine could reasonably  
14 believe that, under the circumstances and  
15 consistent with guidelines, the time re-  
16 quired to go to a participating hospital for  
17 such services could result in any of the ad-  
18 verse health consequences described in a  
19 clause of subsection (a)(2)(A).

20 “(iii) PHYSICIAN REFERRAL.—A par-  
21 ticipating physician or other person au-  
22 thorized by the plan refers the participant  
23 or beneficiary to an emergency department  
24 of a hospital and does not specify an emer-  
25 gency department of a hospital that is a

1 participating hospital with respect to such  
2 services.

3 “(C) APPLICATION OF ‘BEYOND CONTROL’  
4 STANDARDS.—For purposes of applying sub-  
5 paragraph (B)(i), receipt of emergency services  
6 from a nonparticipating hospital shall be treat-  
7 ed under the guidelines as being ‘due to cir-  
8 cumstances beyond the control of the partici-  
9 pant or beneficiary’ if any of the following con-  
10 ditions are met:

11 “(i) UNCONSCIOUS.—The participant  
12 or beneficiary was unconscious or in an  
13 otherwise altered mental state at the time  
14 of initiation of the services.

15 “(ii) AMBULANCE DELIVERY.—The  
16 participant or beneficiary was transported  
17 by an ambulance or other emergency vehi-  
18 cle directed by a person other than the  
19 participant or beneficiary to the non-  
20 participating hospital in which the services  
21 were provided.

22 “(iii) NATURAL DISASTER.—A natural  
23 disaster or civil disturbance prevented the  
24 participant or beneficiary from presenting

1 to a participating hospital for the provision  
2 of such services.

3 “(iv) NO GOOD FAITH EFFORT TO IN-  
4 FORM OF CHANGE IN PARTICIPATION DUR-  
5 ING A CONTRACT YEAR.—The status of the  
6 hospital changed from a participating hos-  
7 pital to a nonparticipating hospital with re-  
8 spect to emergency services during a con-  
9 tract year and the plan or issuer failed to  
10 make a good faith effort to notify the par-  
11 ticipant or beneficiary involved of such  
12 change.

13 “(v) OTHER CONDITIONS.—There  
14 were other factors (such as those identified  
15 in guidelines) that prevented the partici-  
16 pant or beneficiary from controlling selec-  
17 tion of the hospital in which the services  
18 were provided.

19 “(b) ASSURING COORDINATED COVERAGE OF MAIN-  
20 TENANCE CARE AND POST-STABILIZATION CARE.—

21 “(1) IN GENERAL.—In the case of a participant  
22 or beneficiary who is covered under a group health  
23 plan (or under health insurance coverage issued by  
24 a health insurance issuer offered in connection with



1 such a plan) and who has received emergency serv-  
2 ices pursuant to a screening evaluation conducted  
3 (or supervised) by a treating physician at a hospital  
4 that is a nonparticipating provider with respect to  
5 emergency services, if—

6 “(A) pursuant to such evaluation, the phy-  
7 sician identifies post-stabilization care (as de-  
8 fined in paragraph (3)(B)) that is required by  
9 the participant or beneficiary,

10 “(B) the plan or coverage provides benefits  
11 with respect to the care so identified and the  
12 plan requires (but for this subsection) an af-  
13 firmative prior authorization determination as a  
14 condition of coverage of such care, and

15 “(C) the treating physician (or another in-  
16 dividual acting on behalf of such physician) ini-  
17 tiates, not later than 30 minutes after the time  
18 the treating physician determines that the con-  
19 dition of the participant or beneficiary is sta-  
20 bilized, a good faith effort to contact a physi-  
21 cian or other person authorized by the plan or  
22 issuer (by telephone or other means) to obtain  
23 an affirmative prior authorization determination  
24 with respect to the care,

1 then, without regard to terms and conditions speci-  
2 fied in paragraph (2) the plan or issuer shall cover  
3 maintenance care (as defined in paragraph (3)(A))  
4 furnished to the participant or beneficiary during  
5 the period specified in paragraph (4) and shall cover  
6 post-stabilization care furnished to the participant or  
7 beneficiary during the period beginning under para-  
8 graph (5) and ending under paragraph (6).

9 “(2) TERMS AND CONDITIONS WAIVED.—The  
10 terms and conditions (of a plan or coverage) de-  
11 scribed in this paragraph that are waived under  
12 paragraph (1) are as follows:

13 “(A) The need for any prior authorization  
14 determination.

15 “(B) Any limitation on coverage based on  
16 whether or not the physician or provider fur-  
17 nishing the care is a participating physician or  
18 provider with respect to such care.

19 “(C) Any other term or condition of the  
20 plan or coverage (other than an exclusion of  
21 benefits, or an affiliation or waiting period, per-  
22 mitted under section 701 and other than a re-  
23 quirement relating to medical necessity for cov-  
24 erage of benefits).

1           “(3) MAINTENANCE CARE AND POST-STA-  
2           BILIZATION CARE DEFINED.—In this subsection:

3           “(A) MAINTENANCE CARE.—The term  
4           ‘maintenance care’ means, with respect to an  
5           individual who is stabilized after provision of  
6           emergency services, medically necessary items  
7           and services (other than emergency services)  
8           that are required by the individual to ensure  
9           that the individual remains stabilized during  
10          the period described in paragraph (4).

11          “(B) POST-STABILIZATION CARE.—The  
12          term ‘post-stabilization care’ means, with re-  
13          spect to an individual who is determined to be  
14          stable pursuant to a medical screening examina-  
15          tion or who is stabilized after provision of emer-  
16          gency services, medically necessary items and  
17          services (other than emergency services and  
18          other than maintenance care) that are required  
19          by the individual.

20          “(4) PERIOD OF REQUIRED COVERAGE OF  
21          MAINTENANCE CARE.—The period of required cov-  
22          erage of maintenance care of an individual under  
23          this subsection begins at the time of the request (or  
24          the initiation of the good faith effort to make the re-  
25          quest) under paragraph (1)(C) and ends when—

1           “(A) the individual is discharged from the  
2           hospital;

3           “(B) a physician (designated by the plan  
4           or issuer involved) and with privileges at the  
5           hospital involved arrives at the emergency de-  
6           partment of the hospital and assumes respon-  
7           sibility with respect to the treatment of the in-  
8           dividual; or

9           “(C) the treating physician and the plan or  
10          issuer agree to another arrangement with re-  
11          spect to the care of the individual.

12          “(5) WHEN POST-STABILIZATION CARE RE-  
13          QUIRED TO BE COVERED.—

14               “(A) WHEN TREATING PHYSICIAN UNABLE  
15               TO COMMUNICATE REQUEST.—If the treating  
16               physician or other individual makes the good  
17               faith effort to request authorization under para-  
18               graph (1)(C) but is unable to communicate the  
19               request directly with an authorized person re-  
20               ferred to in such paragraph within 30 minutes  
21               after the time of initiating such effort, then  
22               post-stabilization care is required to be covered  
23               under this subsection beginning at the end of  
24               such 30-minute period.

1           “(B) WHEN ABLE TO COMMUNICATE RE-  
2           QUEST, AND NO TIMELY RESPONSE.—

3           “(i) IN GENERAL.—If the treating  
4           physician or other individual under para-  
5           graph (1)(C) is able to communicate the  
6           request within the 30-minute period de-  
7           scribed in subparagraph (A), the post-sta-  
8           bilization care requested is required to be  
9           covered under this subsection beginning 30  
10          minutes after the time when the plan or is-  
11          suer receives the request unless a person  
12          authorized by the plan or issuer involved  
13          communicates (or makes a good faith ef-  
14          fort to communicate) a denial of the re-  
15          quest for the prior authorization deter-  
16          mination within 30 minutes of the time  
17          when the plan or issuer receives the re-  
18          quest and the treating physician does not  
19          request under clause (ii) to communicate  
20          directly with an authorized physician con-  
21          cerning the denial.

22          “(ii) REQUEST FOR DIRECT PHYSI-  
23          CIAN-TO-PHYSICIAN COMMUNICATION CON-  
24          CERNING DENIAL.—If a denial of a request  
25          is communicated under clause (i), the

1           treating physician may request to commu-  
2           nicate respecting the denial directly with a  
3           physician who is authorized by the plan or  
4           issuer to deny or affirm such a denial.

5           “(C) WHEN NO TIMELY RESPONSE TO RE-  
6           QUEST FOR PHYSICIAN-TO-PHYSICIAN COMMU-  
7           NICATION.—If a request for physician-to-physi-  
8           cian communication is made under subpara-  
9           graph (B)(ii), the post-stabilization care re-  
10          quested is required to be covered under this  
11          subsection beginning 30 minutes after the time  
12          when the plan or issuer receives the request  
13          from a treating physician unless a physician,  
14          who is authorized by the plan or issuer to re-  
15          verse or affirm the initial denial of the care,  
16          communicates (or makes a good faith effort to  
17          communicate) directly with the treating physi-  
18          cian within such 30-minute period.

19          “(D) DISAGREEMENTS OVER POST-STA-  
20          BILIZATION CARE.—If, after a direct physician-  
21          to-physician communication under subpara-  
22          graph (C), the denial of the request for the  
23          post-stabilization care is not reversed and the  
24          treating physician communicates to the plan or

1 issuer involved a disagreement with such deci-  
 2 sion, the post-stabilization care requested is re-  
 3 quired to be covered under this subsection be-  
 4 ginning as follows:

5 “(i) DELAY TO ALLOW FOR PROMPT  
 6 ARRIVAL OF PHYSICIAN ASSUMING RE-  
 7 SPONSIBILITY.—If the plan or issuer com-  
 8 municates that a physician (designated by  
 9 the plan or issuer) with privileges at the  
 10 hospital involved will arrive promptly (as  
 11 determined under guidelines) at the emer-  
 12 gency department of the hospital in order  
 13 to assume responsibility with respect to the  
 14 treatment of the participant or beneficiary  
 15 involved, the required coverage of the post-  
 16 stabilization care begins after the passage  
 17 of such time period as would allow the  
 18 prompt arrival of such a physician.

19 “(ii) OTHER CASES.—If the plan or  
 20 issuer does not so communicate, the re-  
 21 quired coverage of the post-stabilization  
 22 care begins immediately.

23 “(6) NO REQUIREMENT OF COVERAGE OF POST-  
 24 STABILIZATION CARE IF ALTERNATE PLAN OF  
 25 TREATMENT.—

1           “(A) IN GENERAL.—Coverage of post-sta-  
 2           bilization care is not required under this sub-  
 3           section with respect to an individual when—

4                   “(i) subject to subparagraph (B), a  
 5                   physician (designated by the plan or issuer  
 6                   involved) and with privileges at the hos-  
 7                   pital involved arrives at the emergency de-  
 8                   partment of the hospital and assumes re-  
 9                   sponsibility with respect to the treatment  
 10                  of the individual; or

11                  “(ii) the treating physician and the  
 12                  plan or issuer agree to another arrange-  
 13                  ment with respect to the post-stabilization  
 14                  care (such as an appropriate transfer of  
 15                  the individual involved to another facility  
 16                  or an appointment for timely followup  
 17                  treatment for the individual).

18           “(B) SPECIAL RULE WHERE ONCE CARE  
 19           INITIATED.—Required coverage of requested  
 20           post-stabilization care shall not end by reason  
 21           of subparagraph (A)(i) during an episode of  
 22           care (as determined by guidelines) if the treat-  
 23           ing physician initiated such care (consistent



1 with a previous paragraph) before the arrival of  
 2 a physician described in such subparagraph.

3 “(7) CONSTRUCTION.—Nothing in this sub-  
 4 section shall be construed as—

5 “(A) preventing a plan or issuer from au-  
 6 thorizing coverage of maintenance care or post-  
 7 stabilization care in advance or at any time; or

8 “(B) preventing a treating physician or  
 9 other individual described in paragraph (1)(C)  
 10 and a plan or issuer from agreeing to modify  
 11 any of the time periods specified in paragraphs  
 12 (5) as it relates to cases involving such persons.

13 “(c) LIMITS ON COST-SHARING FOR SERVICES FUR-  
 14 NISHED IN EMERGENCY DEPARTMENTS.—If a group  
 15 health plan provides any benefits with respect to emer-  
 16 gency services, the plan (or a health insurance issuer offer-  
 17 ing health insurance coverage in connection with such a  
 18 plan) may impose cost sharing with respect to such serv-  
 19 ices only if the following conditions are met:

20 “(1) LIMITATIONS ON COST-SHARING DIF-  
 21 FERENTIAL FOR NONPARTICIPATING PROVIDERS.—

22 “(A) NO DIFFERENTIAL FOR CERTAIN  
 23 SERVICES.—In the case of services furnished  
 24 under the circumstances described in clause (i),  
 25 (ii), or (iii) of subsection (a)(3)(B) (relating to

1           circumstances beyond the control of the bene-  
 2           ficiary, the likelihood of an adverse health con-  
 3           sequence based on layperson's judgment, and  
 4           physician referral), the cost-sharing for such  
 5           services provided by a nonparticipating provider  
 6           or physician does not exceed the cost-sharing  
 7           for such services provided by a participating  
 8           provider or physician.

9           “(B) ONLY REASONABLE DIFFERENTIAL  
 10          FOR OTHER SERVICES.—In the case of other  
 11          emergency services, any differential by which  
 12          the cost-sharing for such services provided by a  
 13          nonparticipating provider or physician exceeds  
 14          the cost-sharing for such services provided by a  
 15          participating provider or physician is reasonable  
 16          (as determined under guidelines).

17          “(2) ONLY REASONABLE DIFFERENTIAL BE-  
 18          TWEEN EMERGENCY SERVICES AND OTHER SERV-  
 19          ICES.—Any differential by which the cost-sharing for  
 20          services furnished in an emergency department ex-  
 21          ceeds the cost-sharing for such services furnished in  
 22          another setting is reasonable (as determined under  
 23          guidelines).

24          “(3) CONSTRUCTION.—Nothing in paragraph  
 25          (1)(B) or (2) shall be construed as authorizing

1 guidelines other than guidelines that establish maxi-  
 2 mum cost-sharing differentials.

3 “(d) INFORMATION ON ACCESS TO EMERGENCY  
 4 SERVICES.—A group health plan (or a health insurance  
 5 issuer, to the extent a health insurance issuer offers group  
 6 health insurance coverage in connection with such a plan)  
 7 shall provide education to participants and beneficiaries  
 8 of the plan on—

9 “(1) coverage of emergency services (as defined  
 10 in subsection (a)(2)(B)) by the plan in accordance  
 11 with the provisions of this section,

12 “(2) the appropriate use of emergency services,  
 13 including use of the 911 telephone system or its  
 14 local equivalent,

15 “(3) any cost sharing applicable to emergency  
 16 services,

17 “(4) the process and procedures of the plan for  
 18 obtaining emergency services, and

19 “(5) the locations of—

20 “(A) emergency departments, and

21 “(B) other settings,

22 in which participating physicians and hospitals pro-  
 23 vide emergency services and post-stabilization care.

24 “(e) GENERAL DEFINITIONS.—For purposes of this  
 25 section:

1           “(1) COST SHARING.—The term ‘cost sharing’  
2       means any deductible, coinsurance amount, copay-  
3       ment or other out-of-pocket payment (other than  
4       premiums or enrollment fees) that a group health  
5       plan (or a health insurance issuer offering group  
6       health insurance issuer in connection with such a  
7       plan) imposes on participants and beneficiaries of  
8       the plan with respect to the coverage of benefits.

9           “(2) GOOD FAITH EFFORT.—The term ‘good  
10      faith effort’ has the meaning given such term in  
11      guidelines and requires such appropriate documenta-  
12      tion as is specified under such guidelines.

13          “(3) GUIDELINES.—The term ‘guidelines’  
14      means guidelines established in accordance with sec-  
15      tion 7 of the Access to Emergency Medical Services  
16      Act of 1997.

17          “(4) NONPARTICIPATING PHYSICIAN OR PRO-  
18      VIDER.—The term ‘nonparticipating physician or  
19      provider’ means, with respect to health care items  
20      and services furnished to a participant or beneficiary  
21      of a group health plan, a physician or provider that  
22      is not a participating physician or provider for such  
23      services.

1           “(5) PARTICIPATING PHYSICIAN OR PRO-  
2           VIDER.—The term ‘participating physician or pro-  
3           vider’ means, with respect to health care items and  
4           services furnished to a participant or beneficiary of  
5           a group health plan, a physician or provider that  
6           furnishes such items and services under a contract  
7           or other arrangement with such plan (or with a  
8           health insurance issuer offering group health insur-  
9           ance coverage in connection with such a plan).

10           “(6) PRIOR AUTHORIZATION DETERMINA-  
11           TION.—The term ‘prior authorization determination’  
12           means, with respect to items and services for which  
13           coverage may be provided under a group health plan,  
14           a determination (before the provision of the items  
15           and services and as a condition of coverage of the  
16           items and services under the plan) of whether or not  
17           such items and services will be covered under the  
18           plan.

19           “(7) STABILIZE.—The term ‘to stabilize’  
20           means, with respect to an emergency medical condi-  
21           tion, to provide (in complying with section 1867 of  
22           the Social Security Act) such medical treatment of  
23           the condition as may be necessary to assure, within  
24           reasonable medical probability, that no material de-  
25           terioration of the condition is likely to result from or

1 occur during the transfer of the individual from the  
2 facility.

3 “(8) STABILIZED.—The term ‘stabilized’  
4 means, with respect to an emergency medical condi-  
5 tion, that no material deterioration of the condition  
6 is likely, within reasonable medical probability, to re-  
7 sult from or occur before an individual can be trans-  
8 ferred from the facility, in compliance with the re-  
9 quirements of section 1867 of the Social Security  
10 Act.

11 “(9) TREATING PHYSICIAN.—The term ‘treat-  
12 ing physician’ includes a treating health care profes-  
13 sional who is licensed under State law to provide  
14 emergency services other than under the supervision  
15 of a physician.

16 “(f) CONTINUED APPLICABILITY OF STATE LAW  
17 WITH RESPECT TO HEALTH INSURANCE ISSUERS.—The  
18 provisions of section 731(a) (relating to State authority  
19 to provide for standards and requirements for health in-  
20 surance issuers to the extent the standards and require-  
21 ments do not prevent the application of a requirement of  
22 this part) apply with respect to the requirements of this  
23 section.”.

24 (b) CONFORMING AMENDMENTS.—

1           (1) Section 731(c) of such Act (29 U.S.C.  
2       1191(c)), as amended by section 603(b)(1) of Public  
3       Law 104–204, is amended by striking “section 711”  
4       and inserting “sections 711 and 713”.

5           (2) Section 732(a) of such Act (29 U.S.C.  
6       1191a(a)), as amended by section 603(b)(2) of Pub-  
7       lic Law 104–204, is amended by striking “section  
8       711” and inserting “sections 711 and 713”.

9           (3) The table of contents in section 1 of such  
10       Act is amended by inserting after the item relating  
11       to section 712 the following new item:

“Sec. 713. Assuring equitable coverage of emergency services, maintenance care,  
and post-stabilization care.”.

12       (c) EFFECTIVE DATE.—(1) Subject to paragraph (2),  
13       the amendments made by this section shall apply to group  
14       health plans for plan years beginning on or after the date  
15       that is 18 months after the date of the enactment of this  
16       Act.

17       (2) In the case of a group health plan maintained  
18       pursuant to 1 or more collective bargaining agreements  
19       between employee representatives and 1 or more employ-  
20       ers ratified before the date of enactment of this Act, the  
21       amendments made by this section shall not apply to plan  
22       years beginning before the later of—

23           (A) the date on which the last collective bar-  
24       gaining agreements relating to the plan terminates

1 (determined without regard to any extension thereof  
 2 agreed to after the date of enactment of this Act),  
 3 or

4 (B) 18 months after the date of the enactment  
 5 of this Act.

6 For purposes of subparagraph (A), any plan amendment  
 7 made pursuant to a collective bargaining agreement relat-  
 8 ing to the plan which amends the plan solely to conform  
 9 to any requirement added by this section shall not be  
 10 treated as a termination of such collective bargaining  
 11 agreement.

12 **SEC. 4. AMENDMENTS TO THE PUBLIC HEALTH SERVICE**

13 **ACT RELATING TO THE GROUP MARKET.**

14 (a) IN GENERAL.—Subpart 2 of part A of title  
 15 XXVII of the Public Health Service Act is amended by  
 16 adding at the end the following new section:

17 **“SEC. 2706. ASSURING EQUITABLE COVERAGE OF EMER-**

18 **GENCY SERVICES, MAINTENANCE CARE, AND**

19 **POST-STABILIZATION CARE.**

20 “(a) PROHIBITION OF CERTAIN RESTRICTIONS ON  
 21 COVERAGE OF EMERGENCY SERVICES.—

22 “(1) IN GENERAL.—If a group health plan pro-  
 23 vides any benefits with respect to emergency services  
 24 (as defined in paragraph (2)(B)), the plan (and any  
 25 health insurance issuer offering health insurance



1 coverage in connection with such a plan) shall cover  
 2 emergency services furnished to a participant or ben-  
 3 eficiary of the plan—

4 “(A) without the need for any prior au-  
 5 thorization determination,

6 “(B) subject to paragraph (3), whether or  
 7 not the physician or provider furnishing such  
 8 services is a participating physician or provider  
 9 with respect to such services, and

10 “(C) subject to paragraph (3), without re-  
 11 gard to any other term or condition of such  
 12 plan or coverage (other than an exclusion of  
 13 benefits, or an affiliation or waiting period, per-  
 14 mitted under section 2701).

15 “(2) EMERGENCY SERVICES; EMERGENCY MEDI-  
 16 CAL CONDITION.—For purposes of this section—

17 “(A) EMERGENCY MEDICAL CONDITION  
 18 BASED ON PRUDENT LAYPERSON.—The term  
 19 ‘emergency medical condition’ means a medical  
 20 condition manifesting itself by acute symptoms  
 21 of sufficient severity (including severe pain)  
 22 such that a prudent layperson, who possesses  
 23 an average knowledge of health and medicine,  
 24 could reasonably expect the absence of imme-  
 25 diate medical attention to result in—

1 “(i) placing the health of the individ-  
2 ual (or, with respect to a pregnant woman,  
3 the health of the woman or her unborn  
4 child) in serious jeopardy,

5 “(ii) serious impairment to bodily  
6 functions, or

7 “(iii) serious dysfunction of any bodily  
8 organ or part.

9 “(B) EMERGENCY SERVICES.—The term  
10 ‘emergency services’ means—

11 “(i) a medical screening examination  
12 (as required under section 1867 of the So-  
13 cial Security Act) that is within the capa-  
14 bility of the emergency department of a  
15 hospital, including ancillary services rou-  
16 tinely available to the emergency depart-  
17 ment, to evaluate an emergency medical  
18 condition (as defined in subparagraph  
19 (A)), and

20 “(ii) within the capabilities of the  
21 staff and facilities available at the hospital,  
22 such further medical examination and  
23 treatment as are required under section  
24 1867 of the Social Security Act to stabilize  
25 the patient.

“(C) TRAUMA AND BURN CENTERS.—The provisions of clause (ii) of subparagraph (B) apply to a trauma or burn center, in a hospital, that—

“(i) is designated by the State, a regional authority of the State, or by the designee of the State, or

“(ii) is in a State that has not made such designations and meets medically recognized national standards.

“(3) APPLICATION OF NETWORK RESTRICTION PERMITTED IN CERTAIN CASES.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), if a group health plan (and an issuer of health insurance coverage in connection with such a plan) denies, limits, or otherwise differentiates in coverage or payment for benefits other than emergency services on the basis that the physician or provider of such services is a nonparticipating physician or provider, the plan and issuer may deny, limit, or differentiate in coverage or payment for emergency services on such basis.

“(B) NETWORK RESTRICTIONS NOT PERMITTED IN CERTAIN EXCEPTIONAL CASES.—

1           The denial or limitation of, or differentiation in,  
2           coverage or payment of benefits for emergency  
3           services under subparagraph (A) shall not apply  
4           in the following cases:

5                   “(i) CIRCUMSTANCES BEYOND CON-  
6                   TROL OF PARTICIPANT OR BENEFICIARY.—

7                   The participant or beneficiary is unable to  
8                   go to a participating hospital for such serv-  
9                   ices due to circumstances beyond the con-  
10                  trol of the participant or beneficiary (as  
11                  determined consistent with guidelines and  
12                  subparagraph (C)).

13                  “(ii) LIKELIHOOD OF AN ADVERSE  
14                  HEALTH CONSEQUENCE BASED ON  
15                  LAYPERSON’S JUDGMENT.—A prudent  
16                  layperson possessing an average knowledge  
17                  of health and medicine could reasonably  
18                  believe that, under the circumstances and  
19                  consistent with guidelines, the time re-  
20                  quired to go to a participating hospital for  
21                  such services could result in any of the ad-  
22                  verse health consequences described in a  
23                  clause of subsection (a)(2)(A).

1                   “(iii) PHYSICIAN REFERRAL.—A par-  
 2                   ticipating physician or other person au-  
 3                   thorized by the plan refers the participant  
 4                   or beneficiary to an emergency department  
 5                   of a hospital and does not specify an emer-  
 6                   gency department of a hospital that is a  
 7                   participating hospital with respect to such  
 8                   services.

9                   “(C) APPLICATION OF ‘BEYOND CONTROL’  
 10                  STANDARDS.—For purposes of applying sub-  
 11                  paragraph (B)(i), receipt of emergency services  
 12                  from a nonparticipating hospital shall be treat-  
 13                  ed under the guidelines as being ‘due to cir-  
 14                  cumstances beyond the control of the partici-  
 15                  pant or beneficiary’ if any of the following con-  
 16                  ditions are met:

17                   “(i) UNCONSCIOUS.—The participant  
 18                   or beneficiary was unconscious or in an  
 19                   otherwise altered mental state at the time  
 20                   of initiation of the services.

21                   “(ii) AMBULANCE DELIVERY.—The  
 22                   participant or beneficiary was transported  
 23                   by an ambulance or other emergency vehi-  
 24                   cle directed by a person other than the

1 participant or beneficiary to the non-  
2 participating hospital in which the services  
3 were provided.

4 “(iii) NATURAL DISASTER.—A natural  
5 disaster or civil disturbance prevented the  
6 participant or beneficiary from presenting  
7 to a participating hospital for the provision  
8 of such services.

9 “(iv) NO GOOD FAITH EFFORT TO IN-  
10 FORM OF CHANGE IN PARTICIPATION DUR-  
11 ING A CONTRACT YEAR.—The status of the  
12 hospital changed from a participating hos-  
13 pital to a nonparticipating hospital with re-  
14 spect to emergency services during a con-  
15 tract year and the plan or issuer failed to  
16 make a good faith effort to notify the par-  
17 ticipant or beneficiary involved of such  
18 change.

19 “(v) OTHER CONDITIONS.—There  
20 were other factors (such as those identified  
21 in guidelines) that prevented the partici-  
22 pant or beneficiary from controlling selec-  
23 tion of the hospital in which the services  
24 were provided.

1       “(b) ASSURING COORDINATED COVERAGE OF MAIN-  
2   TENANCE CARE AND POST-STABILIZATION CARE.—

3               “(1) IN GENERAL.—In the case of a participant  
4       or beneficiary who is covered under a group health  
5       plan (or under health insurance coverage issued by  
6       a health insurance issuer offered in connection with  
7       such a plan) and who has received emergency serv-  
8       ices pursuant to a screening evaluation conducted  
9       (or supervised) by a treating physician at a hospital  
10      that is a nonparticipating provider with respect to  
11      emergency services, if—

12              “(A) pursuant to such evaluation, the phy-  
13      sician identifies post-stabilization care (as de-  
14      fined in paragraph (3)(B)) that is required by  
15      the participant or beneficiary,

16              “(B) the plan or coverage provides benefits  
17      with respect to the care so identified and the  
18      plan requires (but for this subsection) an af-  
19      firmative prior authorization determination as a  
20      condition of coverage of such care, and

21              “(C) the treating physician (or another in-  
22      dividual acting on behalf of such physician) ini-  
23      tiates, not later than 30 minutes after the time

1           the treating physician determines that the con-  
2           dition of the participant or beneficiary is sta-  
3           bilized, a good faith effort to contact a physi-  
4           cian or other person authorized by the plan or  
5           issuer (by telephone or other means) to obtain  
6           an affirmative prior authorization determination  
7           with respect to the care,

8           then, without regard to terms and conditions speci-  
9           fied in paragraph (2) the plan or issuer shall cover  
10          maintenance care (as defined in paragraph (3)(A))  
11          furnished to the participant or beneficiary during  
12          the period specified in paragraph (4) and shall cover  
13          post-stabilization care furnished to the participant or  
14          beneficiary during the period beginning under para-  
15          graph (5) and ending under paragraph (6).

16           “(2) TERMS AND CONDITIONS WAIVED.—The  
17          terms and conditions (of a plan or coverage) de-  
18          scribed in this paragraph that are waived under  
19          paragraph (1) are as follows:

20                   “(A) The need for any prior authorization  
21                  determination.

22                   “(B) Any limitation on coverage based on  
23                  whether or not the physician or provider fur-  
24                  nishing the care is a participating physician or  
25                  provider with respect to such care.



1           “(C) Any other term or condition of the  
2           plan or coverage (other than an exclusion of  
3           benefits, or an affiliation or waiting period, per-  
4           mitted under section 2701 and other than a re-  
5           quirement relating to medical necessity for cov-  
6           erage of benefits).

7           “(3) MAINTENANCE CARE AND POST-STA-  
8           BILIZATION CARE DEFINED.—In this subsection:

9           “(A) MAINTENANCE CARE.—The term  
10          ‘maintenance care’ means, with respect to an  
11          individual who is stabilized after provision of  
12          emergency services, medically necessary items  
13          and services (other than emergency services)  
14          that are required by the individual to ensure  
15          that the individual remains stabilized during  
16          the period described in paragraph (4).

17          “(B) POST-STABILIZATION CARE.—The  
18          term ‘post-stabilization care’ means, with re-  
19          spect to an individual who is determined to be  
20          stable pursuant to a medical screening examina-  
21          tion or who is stabilized after provision of emer-  
22          gency services, medically necessary items and  
23          services (other than emergency services and  
24          other than maintenance care) that are required  
25          by the individual.

1           “(4) PERIOD OF REQUIRED COVERAGE OF  
 2 MAINTENANCE CARE.—The period of required cov-  
 3 erage of maintenance care of an individual under  
 4 this subsection begins at the time of the request (or  
 5 the initiation of the good faith effort to make the re-  
 6 quest) under paragraph (1)(C) and ends when—

7           “(A) the individual is discharged from the  
 8 hospital;

9           “(B) a physician (designated by the plan  
 10 or issuer involved) and with privileges at the  
 11 hospital involved arrives at the emergency de-  
 12 partment of the hospital and assumes respon-  
 13 sibility with respect to the treatment of the in-  
 14 dividual; or

15           “(C) the treating physician and the plan or  
 16 issuer agree to another arrangement with re-  
 17 spect to the care of the individual.

18           “(5) WHEN POST-STABILIZATION CARE RE-  
 19 QUIRED TO BE COVERED.—

20           “(A) WHEN TREATING PHYSICIAN UNABLE  
 21 TO COMMUNICATE REQUEST.—If the treating  
 22 physician or other individual makes the good  
 23 faith effort to request authorization under para-  
 24 graph (1)(C) but is unable to communicate the

request directly with an authorized person referred to in such paragraph within 30 minutes after the time of initiating such effort, then post-stabilization care is required to be covered under this subsection beginning at the end of such 30-minute period.

“(B) WHEN ABLE TO COMMUNICATE REQUEST, AND NO TIMELY RESPONSE.—

“(i) IN GENERAL.—If the treating physician or other individual under paragraph (1)(C) is able to communicate the request within the 30-minute period described in subparagraph (A), the post-stabilization care requested is required to be covered under this subsection beginning 30 minutes after the time when the plan or issuer receives the request unless a person authorized by the plan or issuer involved communicates (or makes a good faith effort to communicate) a denial of the request for the prior authorization determination within 30 minutes of the time when the plan or issuer receives the request and the treating physician does not request under clause (ii) to communicate

1 directly with an authorized physician con-  
2 cerning the denial.

3 “(ii) REQUEST FOR DIRECT PHYSI-  
4 CIAN-TO-PHYSICIAN COMMUNICATION CON-  
5 CERNING DENIAL.—If a denial of a request  
6 is communicated under clause (i), the  
7 treating physician may request to commu-  
8 nicate respecting the denial directly with a  
9 physician who is authorized by the plan or  
10 issuer to deny or affirm such a denial.

11 “(C) WHEN NO TIMELY RESPONSE TO RE-  
12 QUEST FOR PHYSICIAN-TO-PHYSICIAN COMMU-  
13 NICATION.—If a request for physician-to-physi-  
14 cian communication is made under subpara-  
15 graph (B)(ii), the post-stabilization care re-  
16 quested is required to be covered under this  
17 subsection beginning 30 minutes after the time  
18 when the plan or issuer receives the request  
19 from a treating physician unless a physician,  
20 who is authorized by the plan or issuer to re-  
21 verse or affirm the initial denial of the care,  
22 communicates (or makes a good faith effort to  
23 communicate) directly with the treating physi-  
24 cian within such 30-minute period.

1           “(D) DISAGREEMENTS OVER POST-STA-  
2           BILIZATION CARE.—If, after a direct physician-  
3           to-physician communication under subpara-  
4           graph (C), the denial of the request for the  
5           post-stabilization care is not reversed and the  
6           treating physician communicates to the plan or  
7           issuer involved a disagreement with such deci-  
8           sion, the post-stabilization care requested is re-  
9           quired to be covered under this subsection be-  
10          ginning as follows:

11               “(i) DELAY TO ALLOW FOR PROMPT  
12               ARRIVAL OF PHYSICIAN ASSUMING RE-  
13               SPONSIBILITY.—If the plan or issuer com-  
14               municates that a physician (designated by  
15               the plan or issuer) with privileges at the  
16               hospital involved will arrive promptly (as  
17               determined under guidelines) at the emer-  
18               gency department of the hospital in order  
19               to assume responsibility with respect to the  
20               treatment of the participant or beneficiary  
21               involved, the required coverage of the post-  
22               stabilization care begins after the passage  
23               of such time period as would allow the  
24               prompt arrival of such a physician.

1                   “(ii) OTHER CASES.—If the plan or  
 2                   issuer does not so communicate, the re-  
 3                   quired coverage of the post-stabilization  
 4                   care begins immediately.

5                   “(6) NO REQUIREMENT OF COVERAGE OF POST-  
 6                   STABILIZATION CARE IF ALTERNATE PLAN OF  
 7                   TREATMENT.—

8                   “(A) IN GENERAL.—Coverage of post-sta-  
 9                   bilization care is not required under this sub-  
 10                  section with respect to an individual when—

11                  “(i) subject to subparagraph (B), a  
 12                  physician (designated by the plan or issuer  
 13                  involved) and with privileges at the hos-  
 14                  pital involved arrives at the emergency de-  
 15                  partment of the hospital and assumes re-  
 16                  sponsibility with respect to the treatment  
 17                  of the individual; or

18                  “(ii) the treating physician and the  
 19                  plan or issuer agree to another arrange-  
 20                  ment with respect to the post-stabilization  
 21                  care (such as an appropriate transfer of  
 22                  the individual involved to another facility  
 23                  or an appointment for timely followup  
 24                  treatment for the individual).

1           “(B) SPECIAL RULE WHERE ONCE CARE  
 2           INITIATED.—Required coverage of requested  
 3           post-stabilization care shall not end by reason  
 4           of subparagraph (A)(i) during an episode of  
 5           care (as determined by guidelines) if the treat-  
 6           ing physician initiated such care (consistent  
 7           with a previous paragraph) before the arrival of  
 8           a physician described in such subparagraph.

9           “(7) CONSTRUCTION.—Nothing in this sub-  
 10          section shall be construed as—

11           “(A) preventing a plan or issuer from au-  
 12           thorizing coverage of maintenance care or post-  
 13           stabilization care in advance or at any time; or

14           “(B) preventing a treating physician or  
 15           other individual described in paragraph (1)(C)  
 16           and a plan or issuer from agreeing to modify  
 17           any of the time periods specified in paragraphs  
 18           (5) as it relates to cases involving such persons.

19          “(c) LIMITS ON COST-SHARING FOR SERVICES FUR-  
 20          NISHED IN EMERGENCY DEPARTMENTS.—If a group  
 21          health plan provides any benefits with respect to emer-  
 22          gency services, the plan (or a health insurance issuer offer-  
 23          ing health insurance coverage in connection with such a  
 24          plan) may impose cost sharing with respect to such serv-  
 25          ices only if the following conditions are met:

1           “(1) LIMITATIONS ON COST-SHARING DIF-  
2           FERENTIAL FOR NONPARTICIPATING PROVIDERS.—

3           “(A) NO DIFFERENTIAL FOR CERTAIN  
4           SERVICES.—In the case of services furnished  
5           under the circumstances described in clause (i),  
6           (ii), or (iii) of subsection (a)(3)(B) (relating to  
7           circumstances beyond the control of the bene-  
8           ficiary, the likelihood of an adverse health con-  
9           sequence based on layperson’s judgment, and  
10          physician referral), the cost-sharing for such  
11          services provided by a nonparticipating provider  
12          or physician does not exceed the cost-sharing  
13          for such services provided by a participating  
14          provider or physician.

15          “(B) ONLY REASONABLE DIFFERENTIAL  
16          FOR OTHER SERVICES.—In the case of other  
17          emergency services, any differential by which  
18          the cost-sharing for such services provided by a  
19          nonparticipating provider or physician exceeds  
20          the cost-sharing for such services provided by a  
21          participating provider or physician is reasonable  
22          (as determined under guidelines).

23          “(2) ONLY REASONABLE DIFFERENTIAL BE-  
24          TWEEN EMERGENCY SERVICES AND OTHER SERV-  
25          ICES.—Any differential by which the cost-sharing for



1 services furnished in an emergency department ex-  
2 ceeds the cost-sharing for such services furnished in  
3 another setting is reasonable (as determined under  
4 guidelines).

5 “(3) CONSTRUCTION.—Nothing in paragraph  
6 (1)(B) or (2) shall be construed as authorizing  
7 guidelines other than guidelines that establish maxi-  
8 mum cost-sharing differentials.

9 “(d) INFORMATION ON ACCESS TO EMERGENCY  
10 SERVICES.—A group health plan (or a health insurance  
11 issuer, to the extent a health insurance issuer offers group  
12 health insurance coverage in connection with such a plan)  
13 shall provide education to participants and beneficiaries  
14 of the plan on—

15 “(1) coverage of emergency services (as defined  
16 in subsection (a)(2)(B)) by the plan in accordance  
17 with the provisions of this section,

18 “(2) the appropriate use of emergency services,  
19 including use of the 911 telephone system or its  
20 local equivalent,

21 “(3) any cost sharing applicable to emergency  
22 services,

23 “(4) the process and procedures of the plan for  
24 obtaining emergency services, and

25 “(5) the locations of—

1                   “(A) emergency departments, and

2                   “(B) other settings,

3           in which participating physicians and hospitals pro-  
4           vide emergency services and post-stabilization care.

5           “(e) GENERAL DEFINITIONS.—For purposes of this  
6   section:

7                   “(1) COST SHARING.—The term ‘cost sharing’  
8           means any deductible, coinsurance amount, copay-  
9           ment or other out-of-pocket payment (other than  
10          premiums or enrollment fees) that a group health  
11          plan (or a health insurance issuer offering group  
12          health insurance issuer in connection with such a  
13          plan) imposes on participants and beneficiaries of  
14          the plan with respect to the coverage of benefits.

15                  “(2) GOOD FAITH EFFORT.—The term ‘good  
16          faith effort’ has the meaning given such term in  
17          guidelines and requires such appropriate documenta-  
18          tion as is specified under such guidelines.

19                  “(3) GUIDELINES.—The term ‘guidelines’  
20          means guidelines established in accordance with sec-  
21          tion 7 of the Access to Emergency Medical Services  
22          Act of 1997.

23                  “(4) NONPARTICIPATING PHYSICIAN OR PRO-  
24          VIDER.—The term ‘nonparticipating physician or  
25          provider’ means, with respect to health care items

1 and services furnished to a participant or beneficiary  
2 of a group health plan, a physician or provider that  
3 is not a participating physician or provider for such  
4 services.

5 “(5) PARTICIPATING PHYSICIAN OR PRO-  
6 VIDER.—The term ‘participating physician or pro-  
7 vider’ means, with respect to health care items and  
8 services furnished to a participant or beneficiary of  
9 a group health plan, a physician or provider that  
10 furnishes such items and services under a contract  
11 or other arrangement with such plan (or with a  
12 health insurance issuer offering group health insur-  
13 ance coverage in connection with such a plan).

14 “(6) PRIOR AUTHORIZATION DETERMINA-  
15 TION.—The term ‘prior authorization determination’  
16 means, with respect to items and services for which  
17 coverage may be provided under a group health plan,  
18 a determination (before the provision of the items  
19 and services and as a condition of coverage of the  
20 items and services under the plan) of whether or not  
21 such items and services will be covered under the  
22 plan.

23 “(7) STABILIZE.—The term ‘to stabilize’  
24 means, with respect to an emergency medical condi-  
25 tion, to provide (in complying with section 1867 of

1 the Social Security Act) such medical treatment of  
 2 the condition as may be necessary to assure, within  
 3 reasonable medical probability, that no material de-  
 4 terioration of the condition is likely to result from or  
 5 occur during the transfer of the individual from the  
 6 facility.

7 “(8) STABILIZED.—The term ‘stabilized’  
 8 means, with respect to an emergency medical condi-  
 9 tion, that no material deterioration of the condition  
 10 is likely, within reasonable medical probability, to re-  
 11 sult from or occur before an individual can be trans-  
 12 ferred from the facility, in compliance with the re-  
 13 quirements of section 1867 of the Social Security  
 14 Act.

15 “(9) TREATING PHYSICIAN.—The term ‘treat-  
 16 ing physician’ includes a treating health care profes-  
 17 sional who is licensed under State law to provide  
 18 emergency services other than under the supervision  
 19 of a physician.

20 “(f) CONTINUED APPLICABILITY OF STATE LAW  
 21 WITH RESPECT TO HEALTH INSURANCE ISSUERS.—The  
 22 provisions of section 2723(a) (relating to State authority  
 23 to provide for standards and requirements for health in-  
 24 surance issuers to the extent the standards and require-  
 25 ments do not prevent the application of a requirement of

1 this part) apply with respect to the requirements of this  
2 section.”.

3 (b) CONFORMING AMENDMENT.—Section 2723(c) of  
4 such Act (42 U.S.C. 300gg–23(c)), as amended by section  
5 604(b)(2) of Public Law 104–204, is amended by striking  
6 “section 2704” and inserting “sections 2704 and 2706”.

7 (c) EFFECTIVE DATE.—(1) Subject to paragraph (2),  
8 the amendments made by this section shall apply to group  
9 health plans for plan years beginning on or after the date  
10 that is 18 months after the date of the enactment of this  
11 Act.

12 (2) In the case of a group health plan maintained  
13 pursuant to 1 or more collective bargaining agreements  
14 between employee representatives and 1 or more employ-  
15 ers ratified before the date of enactment of this Act, the  
16 amendments made by this section shall not apply to plan  
17 years beginning before the later of—

18 (A) the date on which the last collective bar-  
19 gaining agreements relating to the plan terminates  
20 (determined without regard to any extension thereof  
21 agreed to after the date of enactment of this Act),  
22 or

23 (B) 18 months after the date of the enactment  
24 of this Act.

1 For purposes of subparagraph (A), any plan amendment  
 2 made pursuant to a collective bargaining agreement relat-  
 3 ing to the plan which amends the plan solely to conform  
 4 to any requirement added by this section shall not be  
 5 treated as a termination of such collective bargaining  
 6 agreement.

7 **SEC. 5. AMENDMENTS TO THE PUBLIC HEALTH SERVICE**  
 8 **ACT RELATING TO THE INDIVIDUAL MARKET.**

9 (a) IN GENERAL.—Part B of title XXVII of the Pub-  
 10 lic Health Service Act is amended—

11 (1) by redesignating the subpart 3 relating to  
 12 other requirements as subpart 2, and

13 (2) by adding at the end of such subpart the  
 14 following new section:

15 **“SEC. 2752. ASSURING EQUITABLE COVERAGE OF EMER-**  
 16 **GENCY SERVICES, MAINTENANCE CARE, AND**  
 17 **POST-STABILIZATION CARE.**

18 “(a) IN GENERAL.—The provisions of section 2706  
 19 shall apply to health insurance coverage offered by a  
 20 health insurance issuer in the individual market in the  
 21 same manner as it applies to health insurance coverage  
 22 offered by a health insurance issuer in connection with a  
 23 group plan. In applying the previous sentence, the ref-  
 24 erence in section 2706(b)(2)(C) to section 2701 is deemed  
 25 a reference to subpart 1 of this part.

1       “(b) CONTINUED APPLICABILITY OF STATE LAW  
 2 WITH RESPECT TO HEALTH INSURANCE ISSUERS.—The  
 3 provisions of section 2762 (relating to State authority to  
 4 provide for standards and requirements for health insur-  
 5 ance issuers to the extent the standards and requirements  
 6 do not prevent the application of a requirement of this  
 7 part) apply with respect to the requirements of this sec-  
 8 tion.”.

9       (b) CONFORMING AMENDMENT.—Section 2763(b)(2)  
 10 of such Act (42 U.S.C. 300gg–63(b)(2)), as added by sec-  
 11 tion 605(b)(3)(B) of Public Law 104–204, is amended by  
 12 striking “section 2751” and inserting “sections 2751 and  
 13 2752”.

14       (c) EFFECTIVE DATE.—The amendments made by  
 15 this section shall apply with respect to health insurance  
 16 coverage offered, sold, issued, renewed, in effect, or oper-  
 17 ated in the individual market on or after the date that  
 18 is 18 months after the date of the enactment of this Act.

19 **SEC. 6. APPLICATION TO PRIVATE COVERAGE FOR MEDI-**  
 20 **CARE AND MEDICAID BENEFICIARIES.**

21       (a) MEDICARE.—Subparagraph (B) of section  
 22 1876(c)(4) of the Social Security Act (42 U.S.C.  
 23 1395mm(c)(4)) is amended to read as follows:

1           “(B) meets the requirements of section 2706 of  
 2           the Public Health Service Act with respect to indi-  
 3           viduals enrolled with the organization under this sec-  
 4           tion.”.

5           (b) MEDICAID.—Title XIX of such Act (42 U.S.C.  
 6           1396 et seq.) is amended by inserting after section 1908  
 7           the following new section:

8           “ACCESS TO EMERGENCY SERVICES FOR BENEFICIARIES  
 9                           ENROLLED IN PRIVATE HEALTH PLANS

10          “SEC. 1909. (a) IN GENERAL.—A State plan may  
 11          not be approved under this title unless the plan requires  
 12          each health insurance issuer or other entity with a con-  
 13          tract with such plan to provide coverage or benefits to in-  
 14          dividuals eligible for medical assistance under the plan to  
 15          comply with the provisions of section 2706 of the Public  
 16          Health Service Act with respect to such coverage or bene-  
 17          fits.

18          “(b) COST SHARING.—Nothing in this section or sec-  
 19          tion 2706(c) of the Public Health Service Act shall be con-  
 20          strued as authorizing a health insurance issuer or entity  
 21          to impose cost sharing with respect to the coverage or ben-  
 22          efits described in subsection (a) that is inconsistent with  
 23          the cost sharing that is otherwise permitted under this  
 24          title.



1       “(c) WAIVERS PROHIBITED.—The requirement of  
2 subsection (a) may not be waived under section 1115 or  
3 section 1915(b) of the Social Security Act.”.

4       (c)     MEDICARE     SELECT     POLICIES.—Section  
5 1882(t)(1) of such Act (42 U.S.C. 1395ss(t)(1)) is amend-  
6 ed—

7           (1) in subparagraph (B), by inserting “subject  
8 to subparagraph (G),” after “(B),”

9           (2) by striking “and” at the end of subpara-  
10 graph (E),

11          (3) by striking the period at the end of sub-  
12 paragraph (F) and inserting “; and”, and

13          (4) by adding at the end the following new sub-  
14 paragraph:

15           “(G) the issuer of the policy complies with the  
16 requirements of section 2752 of the Public Health  
17 Service Act with respect to enrollees under this sub-  
18 section.”.

19       (d) EFFECTIVE DATES.—

20           (1) MEDICARE.—The amendment made by sub-  
21 section (a) shall apply to eligible organizations under  
22 section 1876 of the Social Security Act for contract  
23 years beginning on or after the date that is 18  
24 months after the date of the enactment of this Act.

1           (2) MEDICAID.—The amendment made by sub-  
 2           section (b) shall apply to State plans under title  
 3           XIX of the Social Security Act for contract years be-  
 4           ginning on or after the date that is 18 months after  
 5           the date of the enactment of this Act.

6           (3) MEDICARE SELECT.—The amendments  
 7           made by subsection (c) shall apply to policies for  
 8           contract years beginning on or after the date that is  
 9           18 months after the date of the enactment of this  
 10          Act.

11 **SEC. 7. ESTABLISHMENT OF GUIDELINES.**

12          (a) IN GENERAL.—The Secretary of Labor, the Sec-  
 13          retary of Health and Human Services, and the Secretary  
 14          of the Treasury (in this section referred to as “the Sec-  
 15          retaries”) shall, in accordance with the process described  
 16          in subsection (b), jointly establish guidelines to carry out  
 17          section 9811 of the Internal Revenue Code of 1986, sec-  
 18          tion 713 of the Employee Retirement Income Security Act  
 19          of 1974, and sections 2706 and 2752 of the Public Health  
 20          Service Act, including all such guidelines as may be re-  
 21          ferred to in such sections.

22          (b) PROCESS.—

23               (1) ADVISORY PANEL.—Not later than 90 days  
 24               after the date of the enactment of this Act, the Sec-  
 25               retaries shall jointly establish an advisory panel to

1 assist in the development of the guidelines referred  
2 to in subsection (a). The members of the panel shall  
3 include individuals representing—

4 (A) emergency medical personnel, includ-  
5 ing emergency physicians, emergency nurses,  
6 and other appropriate emergency health care  
7 professionals;

8 (B) health insurance issuers, including at  
9 least one health maintenance organization;

10 (C) hospitals;

11 (D) employers;

12 (E) the States; and

13 (F) consumers.

14 (2) NOTICE AND COMMENT.—Not later than  
15 180 days after the date of the enactment of this Act,  
16 the Secretaries shall jointly cause to have published  
17 in the Federal Register notice of proposed rule-  
18 making on the guidelines referred to in subsection  
19 (a). Not later than 60 days after the close of the pe-  
20 riod for public comment on such guidelines, the Sec-  
21 retaries shall jointly cause to have published in the  
22 Federal Register a final rule establishing such guide-  
23 lines.

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